VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

February 3, 2012

Mr. James Beeler, Administrator
Rowan Court Health & Rehab
378 Prospect Street
Barre, VT 05641-5421

Provider #: 475037

Dear Mr. Beeler:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **January 5, 2012.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475037	A. BUILDING _____ B. WING _____	C 01/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWAN COURT HEALTH & REHAB	378 PROSPECT STREET BARRE, VT 05641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted from 1/4/12 to 1/5/12 by the Division of Licensing and Protection. As a result of the investigation, Immediate Jeopardy was identified which also resulted in a determination of Substandard Quality of Care. The findings are as follows.	F 000		
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one applicable resident received services that meet professional standards of quality in regards to accurate medication orders and appropriate medication administration (Resident #1). Findings include: During the investigation from January 4 - January 5, 2012, staff interviews and record review revealed that a series of significant medication errors occurred, affecting Resident #1, in which Resident #1 was given medications without a valid order, without adequate monitoring of the Resident's response to the medications and in the absence of indications for use. Per review of staff notes, Resident #1 was admitted on 12/27/11 for end of life care due to Liver Cancer as alert, oriented, and able to make his/her needs known. From 12/28/11 through the evening of 12/31/11, the resident was noted to be ambulating with a walker independently and was	F 281	F 281 Resident # 1 Admitted for End of Life Care, expired on 1/1/12. Death was from natural causes, with diagnosis of end stage liver cancer/hepatitis C as documented on the death certificate. Systems in place at the time of this isolated incident were operating properly. Policies and Procedures were in place. Verification of the APRN orders was made by 2 nurses at the time the orders were received. The Ambien order was current and available in the medication cart. The facility did add one additional check of physician orders, bringing the total to a three check peer review Nurse #1 has an audit of a medication pass weekly. Nurses #2 and #4 have a monitoring plan in place to ensure that all orders are reviewed by DNS/designee.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/24/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RMC

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F 281	Continued From page 1 able to ask staff when s/he needed medications to treat symptoms. On December 31, 2011, Resident #1 was the recipient of a significant medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication used for insomnia) when the nurse was intending to administer 2 mg of Ativan (an anti-anxiety medication). There is no evidence of this significant medication error in the Resident's medical record nor evidence of ongoing assessments during the following shifts in regards to the potential effects of the medication error. Per record review, Resident #1 had a previous PRN (as needed) order for Ambien 5 mg for insomnia that was discontinued on 12/29/11, but per staff interview with Nurse #1 on 1/4/12, the medication card was still in the medication cart on 12/31/11, available for staff to use. Per record review on 1/4/12, the following telephone orders were transcribed and signed by Nurse #1 on 12/31/11 at 10:30 PM and were not countersigned by the prescribing practitioner: 2 mg Ativan every 4 hours while awake, ABHR cream 1 mg topical every 2 hours scheduled, and 4 mg Morphine subcutaneously every 2 hours throughout the night. ABHR cream is a topical cream that contains 4 medications: Ativan (anti-anxiety), Benadryl (anti-histamine), Haldol (anti-psychotic) and Reglan (used for treatment of nausea). Prior to this telephone order, the dosages of the included medications were as follows for an 'as needed' dose to treat anxiety or agitation, ordered on 12/29/11: 0.5 mg of Ativan, 12.5 mg of Benadryl, 0.5 mg of Haldol, and 10 mg	F 281	All residents receiving medications have the potential to be affected by this alleged deficit practice. Nurses were re-educated on medication administration policy. Nurses were re-educated on the policy and procedure for clinical documentation for medication errors to include not only the incident report but in addition, a notation in the medical record. Nurses were re-educated on the policy for editing and transcribing of physician orders.	

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F 281	Continued From page 2 of Reglan. Per review of drug information, side effects for 3 of 4 of the included medications include drowsiness/sedation. Per interviews on 1/4/12 at 1:40 PM and 1/5/12 at 4:20 PM with the Nurse Practitioner (NP) noted on the telephone order as giving the orders, s/he stated that s/he did not give the above orders to Nurse #1, but gave different orders to Nurse #2 who was not in the facility at the time. The NP verified that s/he did not order Ativan 2 mg to be given every 4 hours while awake, but rather ordered a one time dose of Ativan to be given for increased anxiety that was reported to the NP prior to the significant medication error involving Ambien. The NP also verified that she did not order the ABHR cream to be given every 2 hours scheduled, and also verified that the scheduled Morphine was to be given only throughout the night shift. Prior to this telephone order, the ABHR cream and the Morphine were PRN (as needed) medications to treat complaints of anxiety/agitation and pain, respectively. Throughout the night shift of 12/31/11 - 1/1/12 and through the day shift on 1/1/12, the Morphine and ABHR cream were given by 2 different nurses (Nurse #3 and Nurse #4) every 2 hours per the above mentioned telephone orders written on 12/31/11. Per review of nurses' notes, Resident #1 slept all night from 12/31/11 to 1/1/12, and a note for the day shift of 1/1/12 states the resident slept throughout the shift, and that the nurse continued to administer the ABHR cream and 4 mg Morphine every 2 hours as ordered. The nurses' note by Nurse #3 on 1/1/12	F 281	The nurses responsible for the medication errors were disciplined and re-educated on the medication administration process and medication errors policy. Daily review of new orders will be performed by DNS/designee for triple check by nurses x 90 days. DNS/designee will perform random weekly audits x 90 days of medication passes. DNS/designee will provide enhanced oversight to the nurses that were involved in the medication errors for 90 days. Results of these audits will be reviewed at monthly CQI meeting x 3 months. Date of compliance: January 25, 2012 F281 POC accepted 2/2/12 PMcotaRN	

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F 281	Continued From page 3 also states that the resident was having periods of apnea (temporary cessation of breathing) as early at 9:30 AM, yet staff continued to give the Morphine and ABHR cream in the absence of signs or complaints of pain or anxiety. It was confirmed by Nurse #3 during a telephone interview on 1/5/12 at 1:10 PM, that Resident #1 was not exhibiting signs of, nor made complaints of pain or anxiety during the day on 1/1/12, and the nurse stated that the Morphine was repeatedly given to treat the resident's respiratory symptoms. The 7 doses of ABHR cream given in the absence of signs or complaints of anxiety/agitation from 2:00 AM to 2:00 PM on 1/1/12 were given without indications for use and were based on invalid orders. Also, the 3 doses of Morphine given in the absence of signs or complaints of pain from 9:30 AM to 1:30 PM on 1/1/12 were given without indications for use and without a physician's order to continue with the scheduled dose. There was no order present in the medical record to continue the scheduled Morphine administration into the daytime hours on 1/1/12. There is no evidence of either of the 2 nurses (Nurse #3 or Nurse #4) contacting the prescribing practitioner or physician on-call to question the scheduled administration of the Morphine or ABHR cream when the resident was asleep and/or having periods of apnea. The resident passed away around 3:30 PM on 1/1/12. Per review of the drug manufacturer's prescribing information, the recommended dose of Ambien for patients with liver impairment is 5 mg due to prolonged elimination (the body taking longer to metabolize and eliminate the drug). Precautions	F 281		

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F 281	Continued From page 4 and warnings for Ambien include for patients with liver impairment to use with caution and monitor closely. Drug interactions for Ambien include a statement that it has enhanced CNS depressant effects with combination use. Per review of medication information, Morphine causes respiratory depression, is metabolized by the liver, and is indicated to be used for symptomatic relief from severe pain. Contra-indications listed include respiratory depression. Manufacturer's warnings include a warning to use caution and use Morphine in a reduced dosage in patients who are concurrently receiving other sedatives/hypnotics or central nervous system (CNS) depressants. Precautions for the use of Morphine include a statement that Morphine may have a prolonged duration and cumulative effect in patients with liver dysfunction, stating that in patients with liver dysfunction, the effects of Morphine may last 6, 8 or even up to 24 hours following a standard dose and that continuous administration should be avoided. Listed drug interactions state that Morphine in combination with other tranquilizers, sedative/hypnotics or other CNS depressants has additive depressant effects, stating that a dosage reduction of one or both agents is required. The adverse reactions section states that the major hazards of morphine are respiratory depression, circulatory depression, respiratory arrest, shock and cardiac arrest. Symptoms of overdose include respiratory depression, Cheyne-Stokes respiration, extreme somnolence, and in severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur. References:	F 281		

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F 281	Continued From page 5 Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins, pgs 14 & 17. Pharmaceutical Information: Morphine Sulfate Injection. Retreived January 5, 2012, from http://www.rxmed.com. Highlights of Prescribing Information: Ambien. Retrieved January 5, 2012, from http://products.sanofi.us/ambien/ambien.pdf Pharmaceutical Information: Haldol. Retreived January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retreived January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Ativan. Retrieved January 5, 2012, from http://rxmed.com.	F 281		
F 329 SS=J	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329	F 329 Resident # 1 Admitted for End of Life Care, expired on 1/1/12. Death was from natural causes, with diagnosis of end stage liver cancer/hepatitis C as documented on the death certificate. Systems in place at the time of this isolated incident were operating properly. Policies and Procedures were in place. Verification of the APRN orders was made by 2 nurses at the time the orders were received. The Ambien order was current and available in the medication cart.	

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F 329	Continued From page 6 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one applicable resident was free from unnecessary drugs (Resident #1). Findings include: During the investigation from January 4 - January 5, 2012, staff interviews and record review revealed that a series of significant medication errors occurred, affecting Resident #1, in which Resident #1 was given medications without a valid order, without adequate monitoring of the Resident's response to the medications and in the absence of indications for use. Per review of staff notes, Resident #1 was admitted on 12/27/11 for end of life care from Liver Cancer as alert, oriented, and able to make his/her needs known. From 12/28/11 through the evening of 12/31/11, the resident was noted to be ambulating with a walker independently and was able to ask staff when s/he needed medications to treat symptoms. On December 31, 2011, Resident #1 was the recipient of a significant medication error where the resident received 20 milligrams (mg) of	F 329	The facility did add one additional check of physician orders, bringing the total to a three check peer review Nurse #1 has an audit of a medication pass weekly. Nurses #2 and #4 have a monitoring plan in place to ensure that all orders are reviewed by DNS/designee. All residents receiving medications have the potential to be affected by this alleged deficit practice. Nurses were re-educated on medication administration policy. Nurses were re-educated on the policy and procedure for clinical documentation for medication errors to include not only the incident report but in addition, a notation in the medical record. Nurses were re-educated on the policy for editing and transcribing of physician orders.	

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F 329	Continued From page 7 Ambien (a sedative/hypnotic medication used for insomnia) when the nurse was intending to administer 2 mg of Ativan (an anti-anxiety medication). There is no evidence of this significant medication error in the Resident's medical record nor evidence of ongoing assessments during the following shifts in regards to the potential effects of the medication error. Per record review, Resident #1 had a previous PRN (as needed) order for Ambien 5 mg for insomnia that was discontinued on 12/29/11, but per staff interview with Nurse #1 on 1/4/12, the medication card was still in the medication cart on 12/31/11, available for staff to use. Per record review on 1/4/12, the following telephone orders were transcribed and signed by Nurse #1 on 12/31/11 at 10:30 PM and were not countersigned by the prescribing practitioner: 2 mg Ativan every 4 hours while awake, ABHR cream 1 mg topical every 2 hours scheduled, and 4 mg Morphine subcutaneously every 2 hours throughout the night. ABHR cream is a topical cream that contains 4 medications: Ativan (anti-anxiety), Benadryl (anti-histamine), Haldol (anti-psychotic) and Reglan (used for treatment of nausea). Prior to this telephone order, the dosages of the included medications were as follows for an 'as needed' dose to treat anxiety or agitation, ordered on 12/29/11: 0.5 mg of Ativan, 12.5 mg of Benadryl, 0.5 mg of Haldol, and 10 mg of Reglan. Per review of drug information, side effects for 3 of 4 of the included medications include drowsiness/sedation. Per interviews on 1/4/12 at 1:40 PM and 1/5/12 at 4:20 PM with the Nurse Practitioner (NP) noted	F 329	The nurses responsible for the medication errors were disciplined and re-educated on the medication administration process and medication errors policy. Daily review of new orders will be performed by DNS/designee for triple check by nurses x 90 days. DNS/designee will perform random weekly audits x 90 days of medication passes. DNS/designee will provide enhanced oversight to the nurses that were involved in the medication errors for 90 days. Results of these audits will be reviewed at monthly CQI meeting x 3 months. Date of compliance: January 25, 2012 F329 POC accepted 2/2/12 DMcotaRN	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	Continued From page 8 on the telephone order as giving the orders, s/he stated that s/he did not give the above orders to Nurse #1, but gave different orders to Nurse #2 who was not in the facility at the time. The NP verified that s/he did not order Ativan 2 mg to be given every 4 hours while awake, but rather ordered a one time dose of Ativan 2 mg to be given for increased anxiety that was reported to the NP prior to the significant medication error involving Ambien. The NP also verified that she did not order the ABHR cream to be given every 2 hours scheduled, and also verified that the scheduled Morphine was to be given only throughout the night shift. Prior to this telephone order, the ABHR cream and the Morphine were PRN (as needed) medications to treat complaints of anxiety/agitation and pain, respectively. Throughout the night shift of 12/31/11 - 1/1/12 and through the day shift on 1/1/12, the Morphine and ABHR cream were given by 2 different nurses (Nurse #3 and Nurse #4) every 2 hours per the above mentioned telephone orders written on 12/31/11. Per review of nurses' notes, Resident #1 slept all night from 12/31/11 to 1/1/12, and a note for the day shift of 1/1/12 states the resident slept throughout the shift, and that the nurse continued to administer the ABHR cream and 4 mg Morphine every 2 hours as ordered. The nurses' note by Nurse #3 on 1/1/12 also states that the resident was having periods of apnea (temporary cessation of breathing) as early at 9:30 AM, yet staff continued to give the Morphine and ABHR cream in the absence of signs or complaints of pain or anxiety. It was confirmed by Nurse #3 during a telephone	F 329		

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F 329	Continued From page 9 interview on 1/5/12 at 1:10 PM, that Resident #1 was not exhibiting signs of, nor made complaints of pain or anxiety during the day on 1/1/12, and the nurse stated that the Morphine was repeatedly given to treat the resident's respiratory symptoms. The 7 doses of ABHR cream given in the absence of signs or complaints of anxiety/agitation from 2:00 AM to 2:00 PM on 1/1/12 were given without indications for use and were based on invalid orders. Also, the 3 doses of Morphine given in the absence of signs or complaints of pain from 9:30 AM to 1:30 PM on 1/1/12 were given without indications for use and without a physician's order to continue with the scheduled dose. There was no order present in the medical record to continue the scheduled Morphine administration into the daytime hours on 1/1/12. There is no evidence of either of the 2 nurses (Nurse #3 or Nurse #4) contacting the prescribing practitioner or physician on-call to question the scheduled administration of the Morphine or ABHR cream when the resident was asleep and/or having periods of apnea. The resident passed away around 3:30 PM on 1/1/12. Per review of the drug manufacturer's prescribing information, the recommended dose of Ambien for patients with liver impairment is 5 mg due to prolonged elimination (the body taking longer to metabolize and eliminate the drug). Precautions and warnings for Ambien include for patients with liver impairment to use with caution and monitor closely. Drug interactions for Ambien include a statement that it has enhanced CNS depressant effects with combination use.	F 329		

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F 329	Continued From page 10 Per review of drug information, Morphine causes respiratory depression, is metabolized by the liver, and is indicated to be used for symptomatic relief from severe pain. Contra-indications listed include respiratory depression. Manufacturer's warnings include a warning to use caution and use Morphine in a reduced dosage in patients who are concurrently receiving other sedatives/hypnotics or central nervous system (CNS) depressants. Precautions for the use of Morphine include a statement that Morphine may have a prolonged duration and cumulative effect in patients with liver dysfunction, stating that in patients with liver dysfunction, the effects of Morphine may last 6, 8 or even up to 24 hours following a standard dose and that continuous administration should be avoided. Listed drug interactions state that Morphine in combination with other tranquilizers, sedative/hypnotics or other CNS depressants has additive depressant effects, stating that a dosage reduction of one or both agents is required. The adverse reactions section states that the major hazards of morphine are respiratory depression, circulatory depression, respiratory arrest, shock and cardiac arrest. Symptoms of overdose include respiratory depression, Cheyne-Stokes respiration, extreme somnolence, and in severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur. References: Pharmaceutical Information: Morphine Sulfate Injection. Retreived January 5, 2012, from http://www.rxmed.com. Highlights of Prescribing Information: Ambien.	F 329		

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F 329	Continued From page 11 Retrieved January 5, 2012, from http://products.sanofi.us/ambien/ambien.pdf Pharmaceutical Information: Haldol. Retreived January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retreived January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Ativan. Retrieved January 5, 2012, from http://rxmed.com.	F 329		
F 333 SS=J	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one applicable resident was free of any significant medication errors (Resident #1). Findings include: During the investigation from January 4 - January 5, 2012, staff interviews and record review revealed that a series of significant medication errors occurred, affecting Resident #1. Per review of staff notes, Resident #1 was admitted on 12/27/11 for end of life care for Liver Cancer as alert, oriented, and able to make his/her needs known. From 12/28/11 through the evening of 12/31/11, the resident was noted to be ambulating with a walker independently and was able to ask staff when s/he needed medications to treat symptoms.	F 333	F 333 Resident # 1 Admitted for End of Life Care, expired on 1/1/12. Death was from natural causes with diagnosis of end stage liver cancer/hepatitis C as documented on the death certificate. Systems in place at the time of this isolated incident were operating properly. Policies and Procedures were in place. Verification of the APRN orders was made by 2 nurses at the time the orders were received. The Ambien order was current and available in the medication cart. The facility did add one additional check of physician orders, bringing the total to a three check peer review	

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	475037	A. BUILDING _____ B. WING _____	C 01/05/2012

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F 333	Continued From page 12 On December 31, 2011, Resident #1 was the recipient of a significant medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication used for insomnia) when the nurse was intending to administer 2 mg of Ativan (an anti-anxiety medication). There is no evidence of this significant medication error in the Resident's medical record nor evidence of ongoing assessments during the following shifts in regards to the potential effects of the medication error. Per record review, Resident #1 had a previous PRN (as needed) order for Ambien 5 mg for insomnia that was discontinued on 12/29/11, but per staff interview with Nurse #1 on 1/4/12, the medication card was still in the medication cart on 12/31/11, available for staff to use. Per record review on 1/4/12, the following telephone orders were transcribed and signed by Nurse #1 on 12/31/11 at 10:30 PM and were not countersigned by the prescribing practitioner: 2 mg Ativan every 4 hours while awake, ABHR cream 1 mg topical every 2 hours scheduled, and 4 mg Morphine subcutaneously every 2 hours throughout the night. ABHR cream is a topical cream that contains 4 medications: Ativan (anti-anxiety), Benadryl (anti-histamine), Haldol (anti-psychotic) and Reglan (used for treatment of nausea). Prior to this telephone order, the dosages of the included medications were as follows for an 'as needed' dose to treat anxiety or agitation, ordered on 12/29/11: 0.5 mg of Ativan, 12.5 mg of Benadryl, 0.5 mg of Haldol, and 10 mg of Reglan. Per review of drug information, side effects for 3 of 4 of the included medications include drowsiness/sedation.	F 333	Nurse #1 has an audit of a medication pass weekly. Nurses #2 and #4 have a monitoring plan in place to ensure that all orders are reviewed by DNS/designee. All residents receiving medications have the potential to be affected by this alleged deficit practice. Nurses were re-educated on medication administration policy. Nurses were re-educated on the policy and procedure for clinical documentation for medication errors to include not only the incident report but in addition, a notation in the medical record. Nurses were re-educated on the policy for editing and transcribing of physician orders. The nurses responsible for the medication errors were disciplined and re-educated on the medication administration process and medication errors policy.	

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F 333	Continued From page 13 Per interviews on 1/4/12 at 1:40 PM and 1/5/12 at 4:20 PM with the Nurse Practitioner (NP) noted on the telephone order as giving the orders, s/he stated that s/he did not give the above orders to Nurse #1, but gave different orders to Nurse #2 who was not in the facility at the time. The NP verified that s/he did not order Ativan 2 mg to be given every 4 hours while awake. The NP also verified that she did not order the ABHR cream to be given every 2 hours scheduled, and also verified that the scheduled Morphine was to be given only throughout the night shift. Prior to this telephone order, the ABHR cream and the Morphine were PRN (as needed) medications to treat complaints of anxiety/agitation and pain, respectively. Throughout the night shift of 12/31/11 - 1/1/12 and through the day shift on 1/1/12, the Morphine and ABHR cream were given by 2 different nurses (Nurse #3 and Nurse #4) every 2 hours per the above mentioned telephone orders written on 12/31/11. Per review of nurses' notes, Resident #1 slept all night from 12/31/11 to 1/1/12, and a note for the day shift of 1/1/12 states the resident slept throughout the shift, and that the nurse continued to administer the ABHR cream and 4 mg Morphine every 2 hours as ordered. The nurses' note by Nurse #3 on 1/1/12 also states that the resident was having periods of apnea (temporary cessation of breathing) as early at 9:30 AM, yet staff continued to give the Morphine and ABHR cream in the absence of signs or complaints of pain or anxiety. It was confirmed by the nurse during a telephone interview on 1/5/12 at 1:10 PM, that Resident #1	F 333	Daily review of new orders will be performed by DNS/designee for triple check by nurses x 90 days. DNS/designee will perform random weekly audits x 90 days of medication passes. DNS/designee will provide enhanced oversight to the nurses that were involved in the medication errors for 90 days. Results of these audits will be reviewed at monthly CQI meeting x 3 months. Date of compliance: January 25, 2012 F333 POC accepted 2/2/12 AMcotaRN	

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F 333	Continued From page 14 was not exhibiting signs of, nor made complaints of pain or anxiety during the day on 1/1/12, and the nurse stated that the Morphine was repeatedly given to treat the resident's respiratory symptoms. The 7 doses of ABHR cream administered to Resident #1 without a valid order and in the absence of signs or complaints of anxiety/agitation from 2:00 AM to 2:00 PM on 1/1/12 were significant medication errors. The 3 doses of Morphine given without a valid order and in the absence of signs or complaints of pain from 9:30 AM to 1:30 PM on 1/1/12 were also significant medication errors. There was no order present in the medical record to continue the scheduled Morphine administration into the daytime hours on 1/1/12. There is no evidence of either of the 2 nurses (Nurse #3 or Nurse #4) contacting the prescribing practitioner or physician on-call to question the scheduled administration of the Morphine or ABHR cream when the resident was asleep and/or having periods of apnea. The resident passed away around 3:30 PM on 1/1/12. Per review of the drug manufacturer's prescribing information for Ambien, the recommended dose of Ambien for patients with liver impairment is 5 mg due to prolonged elimination (the body taking longer to metabolize and eliminate the drug). Precautions and warnings for Ambien include for patients with liver impairment to use with caution and monitor closely. Drug interactions for Ambien include a statement that it has enhanced CNS depressant effects with combination use. Per review of drug information, Morphine causes	F 333		

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F 333	Continued From page 15	F 333		

respiratory depression, is metabolized by the liver, and is indicated to be used for symptomatic relief from severe pain. Contra-indications listed include respiratory depression. Manufacturer's warnings include a warning to use caution and use Morphine in a reduced dosage in patients who are concurrently receiving other sedatives/hypnotics or central nervous system (CNS) depressants. Precautions for the use of Morphine include a statement that Morphine may have a prolonged duration and cumulative effect in patients with liver dysfunction, stating that in patients with liver dysfunction, the effects of Morphine may last 6, 8 or even up to 24 hours following a standard dose and that continuous administration should be avoided. Listed drug interactions state that Morphine in combination with other tranquilizers, sedative/hypnotics or other CNS depressants has additive depressant effects, stating that a dosage reduction of one or both agents is required. The adverse reactions section states that the major hazards of morphine are respiratory depression, circulatory depression, respiratory arrest, shock and cardiac arrest. Symptoms of overdose include respiratory depression, Cheyne-Stokes respiration, extreme somnolence, and in severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

References:
Pharmaceutical Information: Morphine Sulfate Injection. Retreived January 5, 2012, from http://www.rxmed.com.

Highlights of Prescribing Information: Ambien. Retrieved January 5, 2012, from http://products.sanofi.us/ambien/ambien.pdf

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F 333	Continued From page 16 Pharmaceutical Information: Haldol. Retreived January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Benadryl. Retreived January 5, 2012, from http://www.rxmed.com. Pharmaceutical Information: Ativan. Retrieved January 5, 2012, from http://rxmed.com.	F 333		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure each resident's clinical record is maintained in accordance with accepted professional standards that are complete and accurately documented for one applicable resident (Resident #1). Findings include: Per record review and interview, Nurse #1 transcribed inaccurate telephone/verbal orders in	F 514	F 514 Resident # 1 Admitted for End of Life Care, expired on 1/1/12. Death was from natural causes with diagnosis of end stage liver cancer/hepatitis C as documented on the death certificate. Systems in place at the time of this isolated incident were operating properly. Policies and Procedures were in place. Resident's increasingly erratic behaviors, increased anxiety, and complaints of pain 12/28/11-12/31/11 required physician notification. Orders were obtained at that time from the APRN (covering for the attending physician) read back for verification by nurse#1 and witnessed by nurse #2.	

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F 514	Continued From page 17 the record of Resident #1, and 2 nurses (Nurse #3 and Nurse #4) implemented the inaccurate orders for Resident #1 from 2:00 AM on 12/31/11 to 2:00 PM on 1/1/12. In addition, there was no documentation of a significant medication error that occurred on 12/31/11 in the medical record. Per review of staff notes, Resident #1 was admitted on 12/27/11 for end of life care due to Liver Cancer as alert, oriented, and able to make his/her needs known. From 12/28/11 through the evening of 12/31/11, the resident was noted to be ambulating with a walker independently and was able to ask staff when s/he needed medications to treat symptoms. On December 31, 2011, per staff interview, Resident #1 was the recipient of a significant medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication used for insomnia) when the nurse was intending to administer 2 mg of Ativan (an anti-anxiety medication). There is no evidence of this significant medication error in the Resident's medical record nor evidence of ongoing assessments during the following shifts in regards to the potential effects of the medication error. Per record review on 1/4/12, the following inaccurate telephone orders were transcribed and signed by Nurse #1 on 12/31/11 at 10:30 PM and were not countersigned by the prescribing practitioner: 2 mg Ativan every 4 hours while awake and ABHR cream 1 mg topical every 2 hours scheduled. ABHR cream is a topical cream that contains 4 medications: Ativan (anti-anxiety), Benadryl (anti-histamine), Haldol (anti-psychotic) and Reglan (used for treatment of nausea).	F 514	Nurses were re-educated on the policy and procedure for clinical documentation for medication errors to include not only the incident report but in addition, a notation in the medical record. The nurses responsible for the medication errors were disciplined and re-educated on the medication administration process and medication errors policy. Daily review of new orders will be performed by DNS/designee for triple check by nurses x 90 days. DNS/designee will perform random weekly audits x 90 days of medication passes. DNS/designee will provide enhanced oversight to the nurses that were involved in the medication errors for 90 days. Results of these audits will be reviewed at monthly CQI meeting x 3 months. Date of compliance: January 25, 2012 F514 POC accepted 2/2/12 RNCotaRN	

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F 514	Continued From page 18 Per interviews on 1/4/12 at 1:40 PM and 1/5/12 at 4:20 PM with the Nurse Practitioner (NP) noted on the telephone order as giving the orders, s/he stated that s/he did not give the above orders to Nurse #1, but gave different orders to Nurse #2 who was not in the facility at the time. The NP verified that s/he did not order Ativan 2 mg to be given every 4 hours while awake, but rather ordered a one time dose of Ativan to be given for increased anxiety that was reported to the NP prior to the significant medication error involving Ambien. The Ativan was not given to Resident #1. The NP also verified that she did not order the ABHR cream to be given every 2 hours scheduled, indicating that the ABHR cream was to be used per a previous order on 12/29/11 on an as needed basis for signs or complaints of anxiety or agitation. Throughout the night shift of 1/1/12 and through the day shift on 1/1/12, the ABHR cream was given by 2 different nurses (Nurse #3 and Nurse #4) every 2 hours scheduled per the above mentioned telephone orders written on 12/31/11. Per review of nurses' notes, Resident #1 slept all night from 12/31/11 to 1/1/12, and a note by Nurse #3 for the day shift of 1/1/12 states the resident slept throughout the shift, and that the nurse continued to administer the ABHR cream as ordered. Resident #1 passed away around 3:30 PM on 1/1/12.	F 514		